

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR SUPPLIER WHITE OAK SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1950 45TH STREET MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 005605</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey August 3-4, 2011</p> <p>Date of ISDH off site review - April 11, 2012</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the August 3-4, 2011 JCAHO Accreditation Survey Report, it has been determined that White Oak Surgery Center meets the requirements for Hospital Licensure in Indiana.</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1